USDA-MRP

WORK RESTRICTION EVALUATION

1. NAME OF EMPLOYEE *(First, Middle, Last)*

2. "X" THE FREQUENCY AND NUMBER OF HOURS A DAY THE WORKER IS ABLE TO DO THE FOLLOWING SPECIFIC TYPES OF ACTIVITIES

	FREQUENCY		NUMBER OF HOURS A DAY								
ACTIVITY	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. Sitting											
b. Walking											
c. Lifting											
d. Bending											
e. Squatting											
f. Climbing											
g. Kneeling											
h. Twisting											
i. Standing											
j. Other (Specify)											

3. LIFTING RESTRICTION (Pounds) ("x" one)
☐ 0-10 ☐ 10-20 ☐ 20-50 ☐ 50-75 ☐ 75 and over

4. CAN THE WORKER REACH OR WORK ABOVE THE SHOULDER?
☐ No ☐ Yes

5. HAND RESTRICTIONS
☐ No ☐ Yes *(complete a, b, and c)*

5a. Simple Grasping
☐ No ☐ Yes

5b. Pushing and Pulling
☐ No ☐ Yes

5c. Fine Manipulation
☐ No ☐ Yes

6. CAN THE WORKER USE HIS/HER FEET TO OPERATE FOOT CONTROLS OR FOR REPETITIVE MOVEMENT?
☐ No ☐ Yes

7. CAN THE WORKER OPERATE A CAR, TRUCK, CRANE, TRACTOR, OR OTHER TYPE OF MOTOR-OPERATED EQUIPMENT?
☐ No ☐ Yes

8. ARE THERE CARDIAC, VISUAL, OR HEARING LIMITATIONS?
☐ No ☐ Yes *(Describe)*

9. ARE THERE RESTRICTIONS CONCERNING HEAT, COLD, DAMPNESS, HEIGHT, TEMPERATURE CHANGES, HIGH SPEED WORKING, OR EXPOSURE TO DUST, FUMES, OR GASES?
☐ No ☐ Yes *(Describe)*

10. ARE INTERPERSONAL RELATIONS EFFECTED BECAUSE OF A NEUROPSYCHIATRIC CONDITION?
☐ No ☐ Yes *(Describe ability to give and take supervision, meet deadlines, etc.)*

11. CAN THE WORKER WORK EIGHT HOURS A DAY?
☐ No ☐ Yes *(Indicate when)*

11a. Can the worker work overtime?
☐ No ☐ Yes *(Indicate when)*

11b. If yes, how many hours and when?

12. DO YOU ANTICIPATE THE WORKER WILL NEED VOCATIONAL REHABILITATION SERVICES SUCH AS TESTING, COUNSELING, TRAINING, OR PLACEMENT TO RETURN TO WORK?
☐ No ☐ Yes

13. HAS THE WORKER REACHED MAXIMUM IMPROVEMENT? *(Indicate when)*
☐ No ☐ Yes

14. IS THE WORKER PHYSICALLY AND MENTALLY ABLE TO PERFORM THE DUTIES OF HIS/HER GOVERNMENT POSITION? *(Job description and performance standards attached)*
☐ No *(Explain)* ☐ Yes

15. WILL THE CONDITION CONTINUE LONGER THAN SIX MONTHS?
☐ No ☐ Yes

16. REMARKS *(Restrictions from medication or other limitations. Use reverse side or additional sheets if necessary)*

17. NAME AND ADDRESS OF PHYSICIAN

18. SIGNATURE OF PHYSICIAN

19. TELEPHONE NUMBER OF PHYSICIAN

20. DATE SIGNED BY PHYSICIAN

This request for information is authorized by 5 CFR Part 339. Information collected will be used for purposes of employment- related decisions and will be handled and stored in compliance with the Freedom of Information Act and the Privacy Act of 1974. The information requested is voluntary; however, benefits/recommendations may not be considered unless this report is completed and filed as requested.